

CDC Press Releases

CDC Telebriefing: CDC update on first Ebola case diagnosed in the United States, 10-07-2014

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Press Briefing Transcript

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- [Audio recording\[MP3, 10 MB\]](#)

BARBARA REYNOLDS: Good afternoon, you're joining CDC's update on the Ebola response. Today, we have two speakers, and then we'll take questions. Our first speaker today is CDC Director, Dr. Tom Frieden.

TOM FRIEDEN: Good morning, everyone. Or good afternoon. Today is one week since the first party with Ebola in the United States was diagnosed, and one week into a situation, people begin to look back and think about it, think about what went right, what went wrong, what are the implications for the future? I think we have to keep a couple things in mind. The first is that globally, this is going to be a long hard fight. The second is that we can never forget that the enemy here is a virus. The enemy is Ebola, not people, not countries, not communities, a virus. It's a virus that doesn't spread through the air, and that we do know how to control. We do know how to stop it. By isolating patients, doing contact tracing, and breaking the chains of transmission. Now, I can say one week in that there are real signs of progress. Not only in Dallas, but also around the world. I'll go through a few of them. In Dallas, there are ten definite and 38 possible contacts being monitored. Each and every one of them is having their temperature monitored. As of today, none of them are sick and none of them have a fever. We'll continue to watch that very closely in the coming days and Dr. Lakey, Judge Shaken and their teams at the state and local level in Dallas are doing a terrific job dealing with what is really an unprecedented situation. In parts of West Africa, we're beginning to see some signs of progress as well. Now, we've been talking about West Africa, but the fact is, these are three different countries and they have three different patterns of disease. Even within each country, there are different patterns of disease so in Liberia there are 15 districts, and in those different districts, there are different patterns of disease. In some, they've had very few cases of Ebola. In others, they are just beginning to have a big increase in cases. I'll mention one particular district, which is in a remote rural area, the capital city known as Lofa. In that district, that was the forested district that is bordering both Sierra Leone and Guinea and that three country border district is what has been the epicenter

of the outbreak. That district, that area has had, at times, the most cases in all of Liberia, but over the past few weeks, cases has plummeted. We're not sure of the reasons, but part is there were enough isolation beds in those facilities — excuse me — and also that in those facilities, in that district, burial practices were being addressed and improved. Now, we don't know that decrease is going to be maintained because we've seen waves of diseases before. We do think that at least in the one community, it's real. So even in West Africa, even in a place that we're at the heart of the outbreak, we're seeing signs of progress. Though it hasn't been in the headlines, the outbreak in DRC is still contained. The number of cases is relatively small. It has not spread beyond a remote rural area. It's the traditional kind of Ebola outbreak in the past, and it looks like it's well on the way to being contained in a country that's dealt with Ebola many times in the past. One other sign of progress that hasn't been in the papers recently or until now is a single case in Uganda of a disease caused by the Marburg virus. Now Marburg is a lot like Ebola, except it didn't have a movie made about it. Marburg has a similar case fatality rate. It's spread in just about the same way, and it's controlled in the same one. One individual died from Marburg. Their cause of death not immediately identified, but we've done important work in Uganda to help the Ugandans better have a laboratory network so they can find cases, have a response network with disease detectives and people who can follow-up, and have an emergency operation center to track individual cases, and as a result, they identified contacts. Those contacts include an individual who was the embalmer who then went back to Kenya. That individual was traced and tracked to Kenya, was tested, does not, at this point, have Marburg, and the contacts within that patient's family in Uganda are being tested, and so far, there's not been additional cases. I mention this because often times in public health, what gets noticed is what happens. It's hard to see what doesn't happen. If we stop the outbreak in rural DRC and we prevent the outbreak of Marburg in Uganda, that may not be headlines, but it tells us that there is progress and gives us confidence we will be able to control Ebola in West Africa. There's a lot we're doing based on what we learned in the past week. For example, we have hospital awareness. We already work regularly with hospital associations. We have an intensive involvement on infection control, technical support, and other issues. Our calls from doctors have increased ten-fold since the first case was diagnosed. There's a lot of awareness, and we're working to increase that even further. We're also working very closely with health departments, city, big city, state, and health department associations. Dr. Lakey and his colleagues in Texas are examples of an excellently functioning health department. We want to make sure any lessons we learn from Dallas are rapidly incorporated into the practice of health departments around the country. I know that people are eager for more information about travel. I want to address that for a couple minutes before concluding and turning it over to Dr. Lakey and then to questions. As the president said yesterday, we're looking hard at what we can do to further increase the safety of Americans, and in the coming days, we'll announce further measures that will be taken. Right now, I can give you some basic principles. We want to ensure, and we are always ensure, that the health of Americans is our top priority. We want to ensure that anything we do works and is workable. We recognize that whatever we do until the disease is controlled in Africa, we can't get the risk to zero here. We may be able to reduce it and we will look at every opportunity to do that. But we also don't to do anything that backfires. In medicine, a cardinal rule is, above all, do no harm. If we do something that impedes our ability to stop the outbreak in West Africa, it could spread further there. We could have more countries like Liberia, and the challenge would be much greater and go on for a much longer period of time. We know how to stop Ebola. That's what's happening in Dallas today. That's

what's beginning to occur in parts of West Africa. The signs of progress are there, but it is going to be a long, hard fight. I think we should always keep in mind that the enemy here is a virus. We, together, can stop that virus. Now I'd like to turn it over to Dr. David Lakey, the commissioner for the Texas department of state health services.

DAVID LAKEY: Thank you Dr. Frieden, and good afternoon to everyone. As Dr. Frieden noted, one week ago today, we learned that a Texas patient had tested positive for Ebola. So I want to thank Dr. Frieden again and the CDC for their support in Dallas. Even as they deal with the national and international issues related to Ebola. Here's a brief update on what's happening in Texas. We're at a very sensitive period when the contact — when a contact could develop symptoms. We're monitoring with extreme vigilance. If a contact develops symptoms, we'll tell you. We'll immediately isolate that individual, test that individual, and increase monitoring as we roll out and confirm Ebola. The contact investigation is going exactly as it should. It is in constant motion. We are posting contact numbers daily. They haven't changed since Sunday. That's always a possibility as we pursue everybody possible contact. The bottom line is that anyone who needs to be monitored will be monitored. I'm also mindful that the rest of Texas and the fact that this one case has on our hospitals. Hospitals are on high alert right now because they don't want to miss anyone who presents with a travel history and symptoms consistent with Ebola. If we get a request for Ebola testing, we'll evaluate that in consultation with the Center for Disease Control and we are capable to do that testing safely and timely. I want us all to remember the people we are monitoring really are real people, and I can't think of anything more unnerving for them right now than this as they wait. We can and will contain the spread of this disease and protect the public by following our core public health measures, and that's what's going on right now in Dallas as we fight against Ebola. Again, thank you, doctor, and thank you, everyone, for being a part of the conference today.

TOM FRIEDEN: Thank you. We'll now take questions starting in the room.

SABRINA TAVERNISE: Sabrina Tavernise, from the New York Times. What explains the ... essentially, does the efforts that have been started in various countries explain differences in cases in the districts that you were mentioning? I mean, what explains the sort of reduction in that very area that had been that hot area that now is not?

TOM FRIEDEN: There are big differences in different areas and some are because of the nature of the spread of disease in those areas. So urban areas may have many more contact per patient, but some are disease control activities. Those include contact tracing, for example, in Conakry, the capital of Guinea, they have done such a good job of contact tracing, that until recently at least, and we'll see if that holds, virtually every one, or nearly every one of the cases that are arise has arisen in a contact was being monitored. That allows them to rapidly stop transmission. Also, we've seen some changes in care giving and burial practices. People learn about Ebola. They learn the risks and change their behaviors. USAID, U.S. Agency for International Development, has contracted for burial teams throughout Liberia, they've been ramping up to improve the proportion of burials done safely and respond to calls for assistance with burying a body. We've also improved infection control in healthcare settings, however, that still has a long way to go. So, we have a long way to go. There's no way to know what the future will hold. No way to know, in some ways what accounts for the progress or whether it will hold, but we are seeing some communities where we've seen progress. Really I would divide the communities in West Africa into three types.

The communities that have very few or no cases of Ebola: there, our focus is preparedness such as what we've done in Uganda, where we create an emergency operation center, we empower the county, we identify a way of testing for the virus, we train and contact tracing, we improve care giving and funeral practices so that we can break the chains in the transmission and we try to keep those areas with lower rates of Ebola and prevent them from having widespread outbreak. There are also areas in these countries that do not have any Ebola cases, and there, you want to make sure there's intensive preparation for the single possible case so you prevent it from spreading widely, and, finally, areas have a lot of case, and there, we break two chains of transmission by getting them in stations, isolated promptly, and if they die, trying to make sure no one gets infected in the process of burying them. We learned a lot how to work with communities most sensitively in that burial process. For example, providing communities with the opportunity to observe bodies as bodies are buried so that they can be part of the ceremony even if they do not touch the body, ensuring that we respect religious traditions in terms of what certain faiths want only people of certain faiths to touch the body of someone who died. Learning those lessons has been very important, and workings with health care workers so that they keep in mind that incredible importance of rigorous infection control.

MEG TERRELL: Meg Terrell from CNBC. I'm just wondering, we've been hearing a lot of news about experimental drugs being used on patients here in the U.S., can you give us any guidance about how you're thinking about that? Whether there's any sort of centralized decision making in the U.S. or any advice coming from a place in the U.S.?

TOM FRIEDEN: In terms of experimental drugs for patients with Ebola, there's a lot of intra. Right now, there were two that we looked at closely: Z Mapp, a combination of three different monoclonal antibodies. It's promising in animal models; it was used in a hand handful of patients. As far as we understand, there's none left in the world and it takes a long time to make more. The second drug, Tekmira is also promising in animal models, although there may be challenges in using it in individual patients. And there's a limited quantity of that available as well. The patient in Texas is getting a third drug, which shows promise in a test tube model of Ebola, and, really, it's up to the doctor, the patient, companies that we have, the NIH, which very involved in drug development, parts of the U.S. Government has been supportive of that within HHS and within the department of defense. It's really an individualized decision, but I would step back a bit and say that what we learned about Ebola is how important it is to get the patient's basic care right so that we're creating their fluid and electrolyte balance well. That's critically important to survival. Let's take a question in the room, and then one more in the room and then to the phone?

JANICE MCDONALD: Janice McDonald from ABC. The Texas patient did receive the experimental drug. Has he had reaction to that, and what other treatment is he receiving other than supportive care?

TOM FRIEDEN: The hospital released the statement saying the patient was incubated, meaning they are on a respirator supporting their breathing. He is on dialysis, getting kidney dialysis to support his kidney functions and received the experimental treatment. He remains in critical condition.

NICK STODDARD: Nick Stoddard with NBC news. There are members of congress that are

urging the CDC to create new guidelines for screenings of Ebola at international airports. Is that something you're working on, something you believe is needed, or is enough being done?

TOM FRIEDEN: We're working very intensively on the screening process as the president said. Both in places of origin and on arrival to the U.S., and we're looking at that entire process to see what more can be done. I want to provide you with information about what is being done now in Africa and here in the U.S. In West Africa, in each of the three countries, CDC has had teams on the ground for several months training people within each country to take a questionnaire and take a temperature of every person getting on a plane to leave the country. That's at the request of the government of these countries. They absolutely understand that keeping travel going is vital to their ability to stop the epidemic and to their ability to continue functioning as society. They are willing to go through any procedures to make it safe. All three of the presidents directly asked me, tell us what more we can do for screening people so we can make sure that airlines keep flying. Because about half of the airlines have cancelled flights and stopped flights since the outbreak started. We, over the past two months, the staff that we trained, who are using thermometers that are calibrated and approved by the Food and Drug Administration for use, and that do not require touch, they use from a few inches away, we've overseen the screening of about 36,000 people who have been boarding planes. Three quarters of those do not come to the U.S. only a small portion come to the U.S. Of those, about 77 had either fever in the case of 74 or symptoms that made us take them off the line in the case of the other three. That's roughly one per 500 travelers. As far as we know, none of the 77 people had Ebola. Many of them had Malaria. Malaria is a disease spread by mosquitoes. It can't be spread from one person to another, but it's extremely common in West Africa and a major source of disease there. If you're finding fever in people from West Africa, the most common single cause of that is going to be Malaria. We'll absolutely look at every step that could tighten that process. Screening at airports, of course, would not have found fever in the patient in Dallas because he did not have fever for four or five days after he arrived, but we'll look at all of the options. We're not, today, providing the step that we plan to take, but I can assure you we will be taking additional steps and will be making those public in the coming days once we work out the details. Let's go to the phone for a couple questions and come back to the room if we have time.

OPERATOR: Thank you, we will begin the question and answer session. If you would like to ask a question, press star one, please remember to unmute your phone, and record your name clearly when prompted. If you want to withdraw, star 2. The first question comes from Caleb Hellerman from CNN. You may ask the question.

CALEB HELLERMAN: Hi, thanks for taking the question. I'm sure you're aware of the case in Spain where a nurse became infected. I'm just curious, I know we don't know the details of the case, but I guess this is more for Dr. Lakey, people more involved in the treatment. Is this giving anyone pause about the protocols recommended in the U.S. and elsewhere? I don't know if you know any more about the specific case, or if it's given you any pause. If you could detail a little more, the precautions that are taken, and recommended?

TOM FRIEDEN: Dr. Lakey, why don't you start, and I'll have a couple of comments at the end.

DAVID LAKEY: Thank you Tom. Obviously we all saw the article, and our concern about what's going on in Spain right now, I would say I personally went to the ward, and I looked at the protocols they are doing right now at Presbyterian hospital, and they take this really, really seriously. They have a ward, a vacant ward except for the individual, caring for him. They have a policy procedure mapped out at one end of the ward, and I guess — I'd also say, I went in the ward, signed in, there's security there, and they have an area where you gown, glove, double glove, hood on, and the appropriate mask, and then also additional personal protective equipment and see the individual and take care of the individual, and they have protocols related to when they are done seeing that individual, making sure they take it off appropriately and that they can shower before they come back out of the ward. As they take this really, really seriously. They've done so from the very beginning. So they are following that meticulous infection control practices, and having said that, again, the unfortunate news that's going on in Spain, it can't help, but to increase the anxiety that's going on right now, but I want to say they doing their work very safely right now, and we continue to watch that. Dr. Frieden.

TOM FRIEDEN: Thank you very much, Dave, and I guess what I would emphasize is that everything we're seeing in Africa and elsewhere suggests that the way Ebola is spreading has not changed. Where we've seen health care worker infections, we have no additional information beyond what's in the media reports about what's happening in Spain. There's also been recent infections in West Africa that are very concerning. We've seen problems; they come in two different contacts: One, when it's a new situation and the health care team has not dealt with Ebola before. Two, if the team is overburdened. If they're dealing with so many patients or have such a staff shortage that it's possible even the best and most meticulous people may cut corners. That's why we've emphasized with global partners while working in West Africa that really four or at the most six weeks is the maximum deployment time, and then you need to rotate out and have another set of individuals there. I know of at least one infection that occurred in an individual, who is known to be very meticulous, and we don't know how the infection occurred, but we know it occurred when the individual extended his stay past six week period, and in two weeks, that individual wanted to continue to provide care, the infection occurred. So ensuring that we have a careful, meticulous, well drilled situation, is very important. I said, and I repeat, we know how to stop Ebola from spreading in hospitals, but that does to the mean it's easy. It's hard. It means you need meticulous attention to detail, you need a team working together, you need to make sure that every aspect of the protocol is rigorously and meticulously followed. In some of the Ebola units in Africa one of the keys to success is having someone in charge of the unit who is very, very experienced and who is roving at all time, identifying anything that is a risk. There are things that have to be checked carefully from the concentration of bleach that's used, to the procedures for putting on and taking off protective equipment, to what actually happens in the Ebola treatment area. Next question on the phone?

OPERATOR: Our next question comes from Eden Brown, Fox News Radio.

EDEN BROWN: Dr. Frieden, Dr. Lakey, thank you for doing this. There was an article in the newspaper today talking where they had epidemiologists who had worked on previous outbreaks of Ebola, and they say they cannot say with certainty that the virus would not lead to other forms, including airborne form, which would certainly change the dynamic of how it

spreads. I'd like you to take a moment to react to that or at least give us your thoughts or opinions or a technical explanation that the rest of us can understand, and then I have a follow-up regarding that.

TOM FRIEDEN: Ebola spreads by direct contact with someone who is sick or with the body fluids of someone who is sick or died from it. We do not see airborne transmission in the outbreak in Africa. We don't see it elsewhere in what we've seen so far. The Ebola virus itself has had a great deal of genetic stability so between the beginnings of the outbreak and more recent isolates, the isolates are about 99.5 percent similar. Even if we look at the virus over the past 50 years since it was first discovered, the rate of change is much slower than many viruses, at less than 5 percent. Furthermore, I know that most viruses do not change how they spread. To do that would require a very large genetic change, and if we look at Ebola as a class of viruses, this is the sub species, here's Ebola, five different sub species of Ebola virus, and they differ by about 40 percent among them, and yet all of them also spread only by direct contact, not by the airborne route. That's not to say that it's impossible that it could change or be selected out for airborne transmission. That would absolutely be the worst case scenario, and we'd know that, not so much from cracking the genetic changes, but by looking at what's happening in Africa. That's why we have teams of epidemiologists from CDC on the ground tracking that, and one of the things we're doing at this point, I discussed earlier, the heterogeneity, the differences within countries. We are now surging the CDC response to go out into the counties most affected, into the areas most affected, and provide intensive support there, for the care of patients, for the tracking of the outbreak, and to see what's happening. Everything we've seen until now does not suggest any change in how Ebola spreads.

EDEN BROWN: Can I follow-up?

TOM FRIEDEN: Please, please.

EDEN BROWN: Transmission, I think, is the ultimate boogy man for a lot of people, especially here in the United States. A lot of the cases that we've seen in the U.S with people being brought in or this Dallas patient, there is — they are able to access a major urban center hospital. For those who live in suburbs and further out where they only have access to immediately anyway to smaller acute hospitals, what's the protocol for them and those hospitals. Are they equipped to handle this and if not how does someone who shows up at a small little hospital that could be a potential Ebola case. What's the protocol to get them to a better doctor? I don't want to say better, but a more in-depth facility?

TOM FRIEDEN: The first point is to suspect Ebola and diagnose it promptly. That's critically important. In terms of the physical arrangements for infection control, you don't need a fancy facility for that. You need a private room with a private bathroom. In terms of the protocols to be followed, we would work with the state and local health departments to support any hospital to do that. It would not be easy, but it can be done and it can be done safely. Next question on the phone. Operator?

OPERATOR: Next is from Bart Jansen, USA Today.

BART JANEN: Thank you for taking the call. Senator Schumer, among others has called for

greater screening of inbound travelers and he said that after meeting with you that he expects you are likely to follow his recommendations. I wondered, for lack of direct flights from these West Africa countries to the U.S., can you say how you determine which airports to boost the screening and how you choose the airport from the passengers?

TOM FRIEDEN: As I said, we're looking intensely at this, and we anticipate announcing new measures in the coming days. What we can do, working with Customs and Border Protection and with Homeland Security is identify even people who arrive by indirect flights and identify airports through which they arrive.

TOM FRIEDEN: Next question on the phone?

OPERATOR: Our next question comes from Kyle Mazza, UNF News

KYLE MAZZA: Hi, thank you for taking my call. This question is for Dr. Lakey, the Texas commissioner of health services. Dr. Lakey, what is your response to help on the ground? Have there been any other cases in Texas at this time? Thank you.

DAVID LAKEY: There have no other cases in Texas. Our hospitals are on high alert. A lot of conversations have taken place with the emergency managers across the state of Texas. I did one earlier today where we have emergency managers on the phone talking about the current situation, and we've had several calls with all the hospitals in the state of Texas. When we do that, we have over a thousand lines open with hospitals talking about what's going on making sure we're prepared. We have one case. We have the case that is currently hospitalized at Presbyterian. We have individuals that are being closely monitored. The contact tracing continues to go forward. They are very vigilant in that, chasing down any rumors, making sure our numbers are solid, and making sure we're meticulous in making sure that every individual that's been identified has been monitoring, but we have the one case that has been identified. Thank you.

KYLE MAZZA: And, Dr. Lakey, if I may, is there any other contacts that you're monitoring who have been tested positive, or are you still waiting on those results at this time?

DAVID LAKEY: There's no other testing of any individuals, and, in fact, as of right now, you know, it wouldn't be surprising if we have another patient from somewhere in Africa or West Africa that comes in when we've done that. We've identified Malaria on individuals, but no additional testing taking place in Texas at this point. We're capable of doing that, we can do it quickly now that we have our laboratory and that capability in the laboratory, but there's no other testing, to my knowledge, and I checked with my folks very carefully, no additional testing in Texas as of right now. Thank you.

TOM FRIEDEN: Just to reiterate, ten contacts with definite contact, 38 with possible contact, none have fever, none have symptoms, all monitored in Texas. The steps that Dr. Lakey describes working with health departments and hospitals throughout Texas, those are steps we are taking nationally. As I mentioned, we'll have a call with health officers from all 50 states and I'll be asking the Dr. Lakey to share some of the key lessons from his experience on that call. We always look to learn from experiences to see what more we can do to ensure that we are consistently improving in our ability to respond. Next question in the room.

SABRINA TAVERNISE: I just wanted to clarify 36,000 and that's over what period of time?

TOM FRIEDEN: Two months, roughly 36,000 over two months. We will take two more questions from the phone and that'll be it.

OPERATOR: Our next question comes from Marillyn Marchione, with the Associated Press.

MARILLYN MARCHIONE: Thank you very much for taking this. The Madrid officials said they are seeking a court order to euthanize the dog of the nursing assistant who tested positive. So I have two questions: Can dogs transmit Ebola to people, and, second, are there any dogs or any other animals involved in the Dallas patient's case or immediate contacts you're monitoring?

TOM FRIEDEN: There is one article in the medical literature that discusses the presence of antibodies to Ebola in dogs. Whether that was an accurate test and whether that was a relevant test, we don't know, but we want to look at all possibilities. We have not identified this as a means of transmission. We do know in rural areas of Africa, that Ebola can infect mammals. In fact, that's how it spreads, from probably bats to animals living in the forest, people hunting the animals. When they hunt the animals and prepare them for serving, they may become infected from the blood that is involved. We don't think this would be a means of transmission, and I can't comment on the specifics of Spain and I'll ask Dr. Lakey to comment on Texas.

DAVID LAKEY: Thank you, Tom. We are not monitoring any animals at this time. I have no knowledge of any animals in the house or exposed. Thank you.

TOM FRIEDEN: Last question on the phone.

OPERATOR: Thank you, our last question comes from Betsy McKay of the Wall Street Journal. Your line's open.

BETSY MCKAY: Hi, thanks. I just wanted to go back to travel screening possibilities for a second. Two of the ideas that have been brought up as likely are reasonable are similar screening methods used in the affected countries so temperature checks and questionnaires for passengers arriving from those country, so I just wonder, Dr. Frieden, if you could comment on, you know, what you think of the possibility of putting those in place in the U.S. Secondly, I just want to ask quickly if CDC has any involvement in the point, at this point, in the investigation of the nurse — the case of the nurse in Spain.

TOM FRIEDEN: In terms of additional travel screening procedures, those two are certainly ones we're looking at carefully. In terms of Spain, I'm not aware that we've been consulted, but happy to do so. Before we close, Dr. Lakey, do you have any last comments?

DAVID LAKEY: Thank you, Dr. Frieden. I again want to thank the CDC for their support here in the state of Texas. We're working very closely with the city, the county, and other state agencies, and the federal government just to make sure we have one team as we do everything we can to ensure that other Texans are not exposed to this disease. This is a very critical week. A lot of monitoring has to take place. Again my message to health care

providers in Texas and across the nation is that you can't diagnose the disease unless you think of this disease. You're not going to think about it unless you do travel history and make sure that everyone knows that information. We'll continue to respond. We'll continue to watch this very, very closely, and we'll continue to be transparent with the information we have, to make sure that if any individual develops symptoms that we tell you. That we'll care for individuals compassionately, isolating them, testing them, and monitoring them as we need to and, again, protect the public's health in the state of Texas. Thank you.

TOM FRIEDEN: Thank you, Dr. Lakey. Thank you, and the team there, for superb work in the contact follow-up and the communications in the community outreach. I know this is a challenging time, and we feel fortunate to be working with you. Bottom line here is that the fight against Ebola in Africa is going to be a long hard fight. The enemy is a virus. It's a difficult virus to stop, but we know how to control it. Tried and true public health measures: Isolation of patients, contact tracing, infection control, safe practices. These make the difference and we're seeing some signs of progress: The excellent response in Dallas, the ongoing control in the DRC, progress in parts of West Africa, but it's going to be a long hard fight, and together, we can contain and control Ebola. Thank you very much.

BARBARA REYNOLDS: Thank you. This concludes the CDC's update on the Ebola response. For reporters who have additional questions, you're welcome to call CDC at 404-639-3286. Thank you.

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